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Patient Handoff Form - Long

Unit Information

Date | Agency Name | Agency Number

PreMiS **Preliminary Report*** Revision 2

Type of Service Requested: ☐ 911 Resp. (Scene) ☐ Interfacility Trans. ☐ Medical Trans. ☐ Standby ☐ Intercept ☐ Mutual Aid

Transport Unit # | Call Sign # | EMT B / I / P | EMT B / I / P | PCR #

Patient Name | Age | Date of Birth | Sex M F | Phone Number | Work Related/Occup.

Patient Address | City | State | Zipcode | Race/Eth. | Social Security Number

Legal Guardian if Patient is a Minor | Relation to Patient | Insurance Company

Situation

Location / Address of Call or Incident ☐ Same as Above

Other Agencies

Response Mode to Scene ☐ Lights and Sirens ☐ No Lights and Sirens ☐ Downgraded to No L&S ☐ Upgraded to L&S

Dispatch Complaint | EMD Performed ☐ EMD Card #

CPR

AED On Scene Prior to EMS	Prior to Arrival	Arrest Witnessed By	Downtime	Performed By:
Yes No	Yes No Time Started	EMS/1st R/PD Family Bystander Unknown	< 5 minutes 5-10 minutes 10-15 minutes Unknown	EMS/1st R PD Family Bystander

Chief Complaint

Duration Min Hrs Days | Severity (1-10)

Other Complaints

Duration Min Hrs Days | Severity (1-10)

Mechanism of Injury

Mechanism or Cause?

☐ Steering Wheel Deformity
☐ Windshield Spider
☐ Dash Deformity
☐ Side Post Deformity
☐ Ejection
☐ DOA Same Vehicle
☐ Rollover
☐ Space Intrusion > 1 ft.
☐ Fire

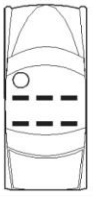
☐ Lap Seat Belt ☐ Shoulder Belt ☐ Helmet ☐ Infant Carseat ☐ Airbag

Extraction Time (min)

Fall (ft)

(Circle Pt. and Vehicle Impact Area)

Car
Sport Utility
Stationwagon
Truck
Van
Motorcycle
Bicycle
Boat



DATES and TIMES

PSAP Call Date/Time
Unit Notified by Dispatch Date/Time
Unit En Route Date/Time
Unit Arrived on Scene Date/Time
Arrived at Patient Date/Time
Unit Left Scene Date/Time
Patient Arrived at Destination Date/Time
Unit Back in Service Date/Time
Unit Back at Home Location Date/Time

ODOMETER

Beginning Odometer
On-Scene Odometer
Destination Odometer
Loaded Mileage

Patient Survey

Vital Signs

Time	BP	HR	RR	Glucose	CO2	SaO2	Temp.

Past History | **Meds**

Evidence of Alcohol Ingestion? Yes No | DNR/MOST Form ☐ | Living Will ☐

Allergies ☐ Denies

Narrative

Protocols Used

Skin	HEENT / Neck	Chest	Heart	Abdomen	Pelvis / Gen.	Extremities	Back
Normal Pale Cyanotic Clammy Jaundiced Cold Warm Diaphoretic	Normal JVD Tracheal Dev. SQ Air Stridor Lac. / Lesion	Normal BS Decreased BS Tenderness Acc. Muscles Flail Segment Rhonchi / Wheezing Rales Lac. / Lesion	Normal Decreased Sounds Murmur Monitor/ECG/FHT'S 1 2	Normal Distention Tenderness Guarding Mass Lac./Lesions R L UQ LQ	Normal Tender Unstable Genital Injury Crowning Lac./Lesions	Normal Tenderness ☐ RUE ☐ LUE ☐ RLE ☐ LLE Abnormalities	Normal Tender Sp. Process No C T L Tender Paraspinous No C T L Pain to ROM No C T L Lac./Lesions

Neuro

Pupils
L: React. Dil __ mm Nonreact. Blind
R: React. Dil __ mm Nonreact. Blind

Findings: Normal | Confused | Combative | Unresponsive | Hallucinations | Seizures | Post-ictal | Obtunded | Tremors

Deficit: Dysphasia | Hemiplegia: R L

Stroke Screen ☐ Positive ☐ Negative

Glasgow Coma Scale

Eyes: Spontaneous 4 | To Voice 3 | To Pain 2 | None 1

Verbal: Oriented 5 | Confused 4 | Inappropriate Sounds 3 | Incomprehensible Sounds 2 | None 1

Motor: Obeys Commands 6 | Localizes to Pain 5 | Withdraws (Pain) 4 | Flexion (Pain) 3 | Extension (Pain) 2 | None 1

Total GCS Score

Adult Trauma Score

Resp. Rate: 10 - 29 = 4 | > 29 = 3 | 6 - 9 = 2 | 1 - 5 = 1 | None = 0

Systolic BP: > 89 = 4 | 76 - 89 = 3 | 50 - 75 = 2 | 1 - 49 = 1 | None = 0

GCS Points: 13 - 15 = 4 | 9 - 12 = 3 | 6 - 8 = 2 | 4 - 5 = 1 | 3 = 0

Total Adult Trauma Score

Reperfusion Check Sheet ☐ No Contraindicators ☐ Contraindicators

Procedures & Medications

Time	Procedure	Size	Tech State ID	Success	Time	Medication	Dose/Route	Tech State ID
				Y N				
				Y N				
				Y N				
				Y N				
				Y N				

Disposition

ETT Confirmation and Signature at Destination

Time | Cardiac Rhythm or 12 Lead Interpretation

Transport Mode from Scene ☐ Lights and Sirens ☐ No Lights and Sirens ☐ Downgraded to No L&S ☐ Upgraded to L&S

Transport	Moved to Ambulance	Transport Position		Safety
☐ Refused ☐ Cancelled	☐ Walk ☐ Stretcher ☐ Carry ☐ Stairchair	☐ Prone ☐ L. Lateral ☐ Trendelenberg ☐ Fowlers	☐ Supine ☐ Sitting ☐ Head Elevated	☐ Gloves ☐ Mask ☐ Gown ☐ Eyewear

Patient's Condition on Arrival: ☐ Improved ☐ Same ☐ Worse

Reason for Choosing Destination (circle): Diversion | Closest Facility | Insurance Status | Family Choice | On-Line Medical Direction | Law Enforcement Choice | Patient Choice | Patient's Physician Choice | Protocol | Specialty Resource Center

Treatment Authorized by MD MICN

Patient Received by

Destination Name and/or Address

EMT Signature | EMT-P | State ID

Medical Control Signature

* This is a preliminary document. This is not the final EMS Patient Care Report.

FORMS

Patient Handoff Form - Short

PreMIS Preliminary Report

1. Patient Information

Patient Name | Age | Date of Birth | Sex ❑ M ❑ F

Patient Address | City | State | Zip Code | Phone Number

2. Unit Information

Agency Name | Agency Number

Unit Number | Call Sign

EMT B / I / P | State ID | EMT B / I / P | State ID

3. Dates and Times

Date

PSAP Call

Unit Notified

Arrived on Scene

Left Scene

Patient at Destination

4. Situation

Location/Address of Call or Incident ❑ Same as Patient Address

Chief Complaint | Onset Date/Time

5. Narrative

6. Vital Signs

Time	BP	HR	RR	Glucose	CO2	SaO2	Temp	GCS	Cardiac Rhythm or 12 Lead Interpretation
:									
:									
:									
:									
:									

Glasgow Coma Score (GCS) Legend

Eye
1 None 2 Pain 3 verbal 4 spontaneous

Verbal
1 none 2 incomprehensible
3 inappropriate words 4 disoriented
5 oriented

Motor
1 no response to pain 2 extends to pain
3 flexes to pain 4 withdraws from pain
5 localizes pain 6 obeys commands

7. Stroke Screen

❑ Positive ❑ Negative ❑ Not Done

8. Reperfusion Check Sheet

❑ No Contraindicators ❑ Contraindicators ❑ Not Done

9. Procedures and Medications

Time	Procedure	Size	Tech ID	Time	Medication	Dose/Route	Tech ID
:				:			
:				:			
:				:			
:				:			
:				:			

10. Disposition

Destination Name and/or Address

11. Signatures

ETT Confirmation and Signature at Destination | EMT Signature | State ID

Treatment Authorized by | MD | MICN | Patient Received by

Medical Control Signature | Room Assignment

This is a Preliminary Document – This is not the final EMS Patient Care Report

FORMS

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
DIVISION OF EMS AND TRAUMA
MEDICAL CONTROL PHYSICIAN CHANGE OR UPDATE FORM

1. SERVICE INFORMATION

Service Name	SC DHEC License Number
Service Mailing Address	
City / State / Zip Code	
Telephone Number	FAX Number:
EMS Service Director E-Mail	

2. MEDICAL CONTROL PHYSICIAN INFORMATION

Name (PRIMARY) Med Control Physician	SC Lic. #	Name (ASSISTANT) Med Control Physician	SC Lic #
E-mail Address (PRIMARY MCP)		E-mail Address (ASSISTANT MCP)	
Mailing Address		Mailing Address	
City / State / Zip		City / State / Zip	
Telephone Number	FAX Number	Telephone Number	FAX Number

STATEMENT OF UNDERSTANDING & AUTHORIZED SIGNATURES:

I have read and understood the duties & Responsibilities of the Medical Control Physician and Section 44-61-130 of the EMS Law also included on this form. Further, if my EMS Service has a State-Approved In-Service Training Program, I accept full responsibility for the program and understand that I may not waive anyone from the state recertification examination until I have attended a State-Approved EMS Medical Control Workshop. If I have not already attended a Medical Control Physician Workshop, I understand that I must attend the next available workshop in order to remain as Medical Control Physician for the above EMS Service.

☐ I Have ☐ I have NOT Attended a Med. Control Workshop

☐ I Have ☐ I have NOT Attended a Med. Control Workshop

Signature PRIMARY Med Control Physician / Date

Signature ASSISTANT Med Control Physician / Date

I understand that I must Notify the SC DHEC Division of EMS & Trauma of any change in Medical Control, Drug List, and/or Standing Orders/Protocols within ten (10) days (Regulation 61-7, § 402 E)

Signature EMS Director

Date

Revision Date: 06-19-2009

STROKE ALERT / SCENE* TOOL PREHOSPITAL CHECKLIST

***South Carolina Emergency Neurologic Evaluation**

DATE & TIMES				
Date:	Dispatch Time:	EMS Arrival:	EMS Departure:	ED Arrival:

BASIC DATA						
Patient name				Age		Gender	
Witness Name				Witness Phone			
Chief Complaint				SBP		DBP	
Last Time Normal		Glucose		Pulse		Resp	

FAST NEUROLOGIC EXAM (Check if abnormal)	YES	NO
Facial Droop (Smile, show teeth)		
Arm Drift (Extend both arms, eyes closed)		
Speech ("You can't teach an old dog new tricks")		

STROKE ALERT CRITERIA	YES	NO
Time of onset < 8 hours		
Positive FAST (=1 or more from FAST NEURO EXAM)		
Blood glucose > 60 mg/dL (if fingerstick possible)		

If YES to all STROKE ALERT CRITERIA, transport to nearest stroke hospital and call Stroke Alert.

Minimize scene time and transport patient urgently.

Destination Hospital:		Hospital Contact:	

PAST HISTORY / MEDICATIONS / ALLERGIES			
Recent events:	PMH:	Medications:	Allergies:

MANAGEMENT REMINDERRS

Do not treat hypertension
Do not allow aspiration (keep NPO)
Provide oxygen (if O2 sat < 94%)
Do not administer glucose (unless glucose < 60 mg / dL)

STROKE SPECIFC REPORT TO EMERGENCY DEPARTMENT

BASIC DATA	SYMPTOMS	HISTORY	EXAM
• Age • Gender • Chief complaint	• Last normal • Trauma • Seizure • Headache	• Recent surgery • Recent illness • Medications • VS & glucose	• GCS • FAST Scale • Other

South Carolina EMS Airway Evaluation Form

1. Patient Demographic Information

Date: _____/_____/_____ Dispatch Time: _____:_____Hrs

PCR#:_____

EMS Agency Name:_____

Patient Age: (yrs)_____ Patient Sex: ❑ M ❑ F

The SC EMS Airway Evaluation Form is required to be completed with ALL intubations.
It is recommended that this form be completed with all invasive airway procedures.

2. Indication for Invasive Airway Management

- ❑ Apnea or Agonal respirations
- ❑ Airway reflex compromised
- ❑ Ventilatory effort compromised
- ❑ Injury / Illness involving airway
- ❑ Adequate airway reflexes / effort – but potential for compromise
- ❑ Other: _____

3. Was endotracheal intubation (ETI) attempted?

❑ YES ❑ No

4. If ETI not attempted, alternate method of airway support

- ❑ Bag-Valve-Mask (BVM)
- ❑ Combitube
- ❑ Needle Jet Ventilation
- ❑ LMA
- ❑ Open Cricothyrotomy
- ❑ Other Cricothyrotomy
- ❑ CPAP / BiPAP
- ❑ King LT-D
- ❑ Not Applicable (ETI Attempted:_____
- ❑ Other: _____

5. Glasgow Coma Score (GCS) before Intubation

EYES: ❑ (1) none ❑ (2) Pain ❑ (3) Verbal ❑ (4) Spontaneous

VERBAL: ❑ (1) None ❑ (2) Incomprehensible ❑ (3) Inappropriate Words ❑ (4) Disoriented ❑ (5) Oriented

MOTOR: ❑ (1) No Response ❑ (2) Extends to Pain ❑ (3) Flexes to Pain ❑ (4) Withdraws from Pain ❑ (5) Localizes Pain ❑ (6) Obeys Commands

6. Level of training of each rescuer attempting intubation

Rescuer A	Rescuer B	Rescuer C
State ID:_____	State ID:_____	State ID:_____
❑ Paramedic	❑ Paramedic	❑ Paramedic
❑ Nurse	❑ Nurse	❑ Nurse
❑ Respiratory Therapist	❑ Respiratory Therapist	❑ Respiratory Therapist
❑ Physician Assistant	❑ Physician Assistant	❑ Physician Assistant
❑ Nurse Practitioner	❑ Nurse Practitioner	❑ Nurse Practitioner
❑ MD / DO	❑ MD / DO	❑ MD / DO
❑ Other:_____	❑ Other:_____	❑ Other:_____

7. Indicated drugs given to facilitate intubation

- ❑ Atropine_____ mg
- ❑ Diazepam_____ mg
- ❑ Etomidate_____ mg
- ❑ Lidocaine_____ mg
- ❑ Midazolam_____ mg
- ❑ Morphine_____ mg
- ❑ Succinylcholine_____ mg
- ❑ Topical Anestheic Spray
- ❑ Other – Specify:_____ mg
- ❑ Other – Specify:_____ mg

8. Times and Vital Signs

	Time	Heart Rate	Resp. Rate	Blood Pressure	Pulse Oximetry	$EtCO_2$
Decision to Perform Airway Procedure	:					
Pre-Airway Procedure Value	:			/		
Lowest Value During Airway Procedure	:			/		
Highest Value During Airway Procedure	:			/		
Successful Airway Obtained	:					
Post-Airway Procedure Value	:			/		
Airway Procedure Abandoned Unsuccessfully	:					

South Carolina EMS Airway Evaluation Form

9. Provide information for each laryngoscopy attempt.

Attempt	ETI Method	Rescuer	Attempt Successful
1	❑ Oral ❑ Nasal ❑ Sedation ❑ RSI	❑ A ❑ B ❑ C	❑ Yes ❑ No
2	❑ Oral ❑ Nasal ❑ Sedation ❑ RSI	❑ A ❑ B ❑ C	❑ Yes ❑ No
3	❑ Oral ❑ Nasal ❑ Sedation ❑ RSI	❑ A ❑ B ❑ C	❑ Yes ❑ No
4	❑ Oral ❑ Nasal ❑ Sedation ❑ RSI	❑ A ❑ B ❑ C	❑ Yes ❑ No

FOR ORAL ROUTE: Each Insertion of Blade (Laryngoscope) is one "Attempt"

FOR NASAL ROUTE: Each Pass of Tube Past the Nares is one "Attempt"

10. Endotracheal tube confirmation

	Tracheal Placement	Esophageal Placement	Indeterminate	Not Assessed	Tube Not Placed
Auscultation	❑	❑	❑	❑	❑
Bulb/Syringe Aspiration	❑	❑	❑	❑	❑
Colorimetric $EtCO_2$	❑	❑	❑	❑	❑
Digital $EtCO_2$	❑	❑	❑	❑	❑
Waveform $EtCO_2$	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑

11. Who determined the final placement (location) of ET Tube?

- ❑ Rescuer performing intubation
- ❑ Another rescuer on the same team
- ❑ Receiving helicopter/EMS crew
- ❑ Receiving hospital team
- ❑ Other: _____

12. Was ETI successful for the overall encounter(on transfer of care to ED or helicopter)?

❑ YES ❑ No

13. If all intubation attempts FAILED, indicate suspected reasons for failed intubation (Check *all* that apply)

- ❑ Inadequate patient relaxation
- ❑ Inability to expose vocal cords
- ❑ Difficult patient anatomy
- ❑ ETI attempted, but arrived at destination facility before accomplished
- ❑ Not Applicable – Successful field ETI
- ❑ Orofacial Trauma
- ❑ Secretions/blood/vomit
- ❑ Unable to access patient
- ❑ Other _____

14. Critical complications encountered during airway management (Check *all* that apply)

- ❑ Failed intubation effort
- ❑ Injury or trauma to patient from airway management effort
- ❑ Adverse event from facilitating drugs
- ❑ Esophogeal intubation – delayed detection (after tube secured)
- ❑ Esophogeal intubation – detected in ED
- ❑ Tube dislodged during transport/patient care
- ❑ Tube was not in the correct position when assumed care of the patient
- ❑ Other: _____

15. If all intubation attempts FAILED, indicate secondary (rescue) airway technique used (Check *all* that apply)

- ❑ Bag-Valve-Mask (BVM) Ventilation
- ❑ Combitube
- ❑ Not Applicable – Successful field ETI
- ❑ Other _____
- ❑ Needle/Jet Ventilation
- ❑ Open Cricothyroidotomy
- ❑ King LT-D

16. Did secondary (rescue) airway result in satisfactory ventilation?

❑ Yes ❑ No ❑ Not Applicable

18. Endotracheal tube confirmation

34. ❑ Size (mm) _____ ❑ Unknown
35. ❑ Depth (cm, at lateral corner of mouth) _____ ❑ Unknown
36. Secured with: ❑ Adhesive tape Umbilical/cloth tape ❑ Tube holder ❑ Other ❑ Unknown
37. Placement reassessed after patient movement ❑ Yes ❑ No ❑ Unknown
38. Placement reassessed after patient transfer of care ❑ Yes ❑ No ❑ Unknown

19. Signature of Receiving Physician/Healthcare Provider (Confirming Destination/Transfer Tube Placement)

Date and Time: ____ : ____ am/pm

20. Signature of EMS Medical Director (Confirming Review of Completed Form)

Date:

DHEC
PROMOTE PROTECT PROSPER

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to

_____ that he/she has a terminal condition which has been diagnosed by me and has
(Name of Patient)

specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MULTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date	Patient's Signature (or Surrogate or Agent)
Physician's Name (Please Print)	Physician's Signature
Physician's Address	Physician's Telephone Number

DHEC 3462 (12/2000) **SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL**